1 2 16004

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16016

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Ella | Cornelia | Bacon | October 20, 1971 | 10:17 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| female | negro | April 27, 1884 | 87 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Pine Bluff State Hosp. | housewife | - |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | X | 19 Kiowa Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | - | Hayman | Martha | - | Smith |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No - | 194-05-0838 | records of | Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | arteriosclerotic cardiovascular disease | unknown |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that ☒ (this hospital) attended the deceased from Aug. 6, 19 71, to Oct. 20, 19 71, that ☒ (we) last saw the deceased alive on Oct. 20 19 71, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | ☐ | ☒ | ☐ | Oct. 21, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/26/71 | John Wesley | Princess Anne, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| William H. Jones Princess | OCT 27 1971 | Vernon A. Rudick |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16005

# CERTIFICATE OF DEATH

16017

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25m-1/70

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Bessie | Middle: M. | Last: Bailey | 2a. DATE OF DEATH Month: 10 Day: 5 Year: 71 | 2b. HOUR: 2:58 PM |
| 3. SEX: Female | 4. RACE: Col | 5. DATE OF BIRTH: 4/18-99 | 6. AGE (In years last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Wicomico | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Co | | Md. |
| 10. CITY OR TOWN OF DEATH: Delmar | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Nanticoke | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: RR one | |
| 14. FATHER'S NAME First: Steven | Middle: | Last: Snader | 15. MOTHER'S MAIDEN NAME First: Edith | Middle: | Last: ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 22-16-5562 | 17. INFORMANT: Joseph Bailey | Address: | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO, OR AS A CONSEQUENCE OF
(b): Ischemic heart disease — unknown
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** that (I) (this hospitol) attended the deceased from 5/10, 19 56, to death, 19____, that (I) (we) last saw the deceased alive on 10/14 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Ernest Larmore | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 10/11/71 | |
| 22d. PHYSICIAN'S NAME (Type): E LARMORE | 22e. ADDRESS: DELMAR DEL. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Buried | 23b. DATE: 10-19-71 | 23c. NAME OF CEMETERY OR CREMATORY: Union Cem | 23d. LOCATION (City or Town) Delmar (County) (State) Md. |
| 24. FUNERAL DIRECTOR: Baker M West | ADDRESS: | 25a. REC'D BY REGISTRAR DATE: OCT 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16006 — 17601

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Roland | Middle J. | Last Ballard |
| 2a. DATE OF DEATH Month | October | Day 19 | Year 1971 |
| 2b. HOUR | | | M |
| 3. SEX | Male | | |
| 4. RACE | Negro | | |
| 5. DATE OF BIRTH | 1-10-93 | | |
| 6. AGE (In years last birthday) | 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) | Deal Island | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Somerset |
| 13c. CITY OR TOWN | Deal Island | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER P.O. Box |
| 14. FATHER'S NAME First / Middle / Last | James Ballard | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Harriet Collman |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | no. (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT | Marion Ballard | Address | 5427 Hanover Rd. Phila. Pa. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignit Lymphoma stages 2022.
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1YR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medicol exominer) | UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 10-1, 19 71, to 10-17, 19 71, that (I) (we) last saw the deceased alive on 10-17 19 71, and that in (my) (our) opinion death occurred an the date and hour and from the causes stoted above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Nevins W. Todd M DEGREE | ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED 11-5-71 |
| 22d. PHYSICIAN'S NAME (Type) | Nevins W. Todd, M.D. | 22e. ADDRESS | Medical Center, Salisbury, Md. |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE 10-23-71 | 23c. NAME OF CEMETERY OR CREMATORY | John Wesley United |
| 23d. LOCATION (City or Town) (County) (State) | Deal Island Som. Md. | | | |
| 24. FUNERAL DIRECTOR | Dalley Funeral Home | ADDRESS | Jersey Rd. Salis. Md. | |
| 25a. REC'D BY REGISTRAR DATE | NOV 12 1971 | 25b. REGISTRAR'S SIGNATURE | Norman A. Randall | |

VR A15(4) 25m-1/70

~~13~~ 16007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

16018

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: MAUDE Middle: L. Last: BIRCH | 2a. DATE OF DEATH Month 10 Day 3 Year 71 | 2b. HOUR M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: FEB 8, 1883 | 6. AGE (In years lost birthday) 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: WICOMICO Md. |
| 10. CITY OR TOWN OF DEATH: SALISBURY | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SALISBURY NURSING HOME | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WOR | 13c. CITY OR TOWN: BERLIN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: 200 WASHINGTON | | | |
| 14. FATHER'S NAME First: DAVID Middle: Last: PUSEY | 15. MOTHER'S MAIDEN NAME First: MARY Middle: Last: GUTHRIE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MRS. MINNIE TAYLOR SNOW HILL MD | |

90
23
2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4339

IMMEDIATE CAUSE (a) Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from Feb, 1971, to 10/3, 1971, that (I) (we) last saw the deceased alive on 10/2 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 10/7/71

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 10/7/71 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: BOWEN | 23d. LOCATION (City or Town) (County) (State): NEWARK WOR MD. |
| 24. FUNERAL DIRECTOR: Anna A. Burbage | ADDRESS: Berlin Md. | 25a. REC'D BY REGISTRAR DATE: OCT 13 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon P. Randall |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71-30M (VR A15 (4))

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16008 — 16019

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Bronie | Benson | Boinovych. | 10 | 2 | 71 | 10 A. M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| 7 | W | 2-20-1918 | 53 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Elkton, Md. | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Cashier, Glen L. Martin Co. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Cecil | Elkton | YES [ ] NO [X] | R. D. #2 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Raymond | | Fronk | Lillian | Mae | Deibert |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| no | 161-12-0402 | Peter Boinovych RD #2, Elkton, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma Colon & Metastasis | 1 1/2 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Debilitation due to (1) | 1 Month. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Anemia due to (1) | 1 Month. |

1538

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Sept. 28, 19 71, to Oct. 2, 19 71, that (I) (we) last saw the deceased alive on Oct. 2 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John J. Cahaco MD. | | | | [X] | 10-2-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| JOHN J. CAHACO MD | Deers Head State Hosp. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Oct. 6, 1971 | Elkton Cemetery | Elkton | Cecil | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| PIPPIN FUNERAL HOME | Elkton, Md. | OCT 6 1971 | Vernon A. Randolph |

VR A15-(4) 25m-1170

1 ~~10~~

16009

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16020

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: GRACE Middle: Smith Last: BONTE | 2a. DATE OF DEATH Month: October Day: 22 Year: 1971 | 2b. HOUR: 7 P.M. 45 | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Sept 14, 1901 | 6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Mississippi | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Siloam | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET AND NUMBER: Rt #2 Eden |
| 14. FATHER'S NAME First: William Middle: Last: Smith | 15. MOTHER'S MAIDEN NAME First: Ida Middle: Last: Reynolds | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): — | 16b. SOCIAL SECURITY NO.: 216-46-3949 | 17. INFORMANT: HANS Bonte Address: See Sec 13 | |

80 22 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

1929

IMMEDIATE CAUSE (a) Ependymoma of spinal cord

DUE TO, OR AS A CONSEQUENCE OF (b) vault

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: Sept. 9/21/71 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: INCREASE INTRA CRAN. PRESS CORD COMPRESSION | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from July 10, 1971, to Oct 22, 1971, that (I) (we) last saw the deceased alive on Oct 22 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Shoemaker M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED: 10/23/71

22d. PHYSICIAN'S NAME (Type): Dr. H Shoemaker 22e. ADDRESS: Salisbury, Maryland

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation | 23b. DATE: 10-26-1971 | 23c. NAME OF CEMETERY OR CREMATORY: J. Wm. Lee's Crematory | 23d. LOCATION (City or Town) (County) (State): Washington D.C. |
| 24. FUNERAL DIRECTOR: Hill-Baker-Bounds Funeral Home | ADDRESS: Salisbury, Maryland | 25a. REC'D BY REGISTRAR DATE: OCT 26 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all bar papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25m-1/70

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16010 16021

1. DECEASED-NAME (Type or print): First Marcus Middle Frederick Last BROOKS
2a. DATE OF DEATH: Month October Day 11 Year 1971
2b. HOUR: 10:30 PM
3. SEX: MALE
4. RACE: Negro
5. DATE OF BIRTH: 10-11-71
6. AGE (In years last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS 47 MIN. 26
7a. BIRTHPLACE (State or foreign country): Salisbury
7b. CITIZEN OF WHAT COUNTRY? U.S.A
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Overbrook Drive - Rt #2 Salisbury Md.
14. FATHER'S NAME First Gethan Middle Watts Last
15. MOTHER'S MAIDEN NAME First Stella Middle Lost Brooks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: Stella Brooks - Overbrook Dr. Rt #2 Address: Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline Membrane Disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7761
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 47 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Prematurity

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☑ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10-9, 19 71, to 10-11, 19 71, that (I) (we) last saw the deceased alive on 10-11 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: D. S. Anderson M.D. DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-13-71
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-18-71
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION (City or Town) (County) (State): Salisbury Wico. Md.
24. FUNERAL DIRECTOR: Jolley Memorial Chapel ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: OCT 21 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

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16011

16022

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4-70) 25m-1/70

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | HOWARD / JAMES / CAMPBELL | 2a. DATE OF DEATH Month / Day / Year | October 31 1971 |
| 2b. HOUR | 8:20 PM | | |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH | 1-15-1901 | 6. AGE (In years last birthday) | 70 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | DeLaware | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hosp. |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Retired Salesman Auto. | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET AND NUMBER | 719 Alvin Ave | | |
| 14. FATHER'S NAME First / Middle / Last | Charles / / Campbell | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Myrna |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 214-10-9950 |
| 17. INFORMANT Address | Mrs. Ruth King Campbell See Sec 13 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Embolus with hemiplegia

DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS ☐ UNDERLYING CAUSE OF DEATH ☐ CONTRIBUTING (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9-29- 19 71, to 10-31- 19 71, that (I) (~~we~~) last saw the deceased alive on 10-31- 19 71, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | James L. Clifford DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 10-31-71 |
| 22d. PHYSICIAN'S NAME (Type) | James L. Clifford M.D. | 22e. ADDRESS | Medical Center Salisbury Md |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) (State) |
| BURIAL | 11-2-1971 | Parsons Cemetery | Salisbury | Wic. Md. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
| Hill-Baker-Bounds Funeral Home | Salisbury, Maryland | NOV 4 1971 | Vernon G. Randall |

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16012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16023

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: JOE Middle: Lost: CHESSON | 2a. DATE OF DEATH Month: October Day: 29 Year: 1971 | 2b. HOUR: 10 A.M. | |
| 3. SEX: MALE | 4. RACE: NEGRO | 5. DATE OF BIRTH: 12-2-05 | 6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): N.C. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Willard | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: Rt #2 Box Willard Md. 346 | | | |
| 14. FATHER'S NAME First: Prince Middle: Chesson Lost: | 15. MOTHER'S MAIDEN NAME First: Rosetta Middle: El Pierce Last: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 243-16-6853 | 17. INFORMANT: Viola Thomas - 2873 W. Lanvale St. Address: Balt. Md. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: since 10/20/71
4124
DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema + Pul fibrosis
DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 10/20, 1971, to 10/29, 1971, that (I) (we) lost saw the deceased alive on 10/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Alberta Polin DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ | 22c. DATE SIGNED: 10/30/71 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 11-3-71 | 23c. NAME OF CEMETERY OR CREMATORY: GREEN ACRES | 23d. LOCATION (City or Town) (County) (State): Salisbury Wico Md. |
| 24. FUNERAL DIRECTOR: Jolley Funeral Jersey Rd. Salis. Md. ADDRESS | 25a. REC'D BY REGISTRAR DATE: NOV 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (5-4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16013 16024

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, use the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Joseph | Middle: M. | Last: CORNISH | 2a. DATE OF DEATH: Month: OCTOBER Day: 12 Year: 1971 |
| 2b. HOUR: 12 P.M. | | | |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: 2/13/1907 | 6. AGE (In years last birthday): 64 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: Davis, Street | | | |
| 14. FATHER'S NAME First: Joseph | Middle: Cornish Sr. | Last: | 15. MOTHER'S MAIDEN NAME First: Unkown | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Beverly Cornish 114 Second St. | Address: Salis. Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Obstructive Emphysema
DUE TO, OR AS A CONSEQUENCE OF (b): with Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |

22a. I **certify** thot (I) ~~(this hospital)~~ attended the deceased from Oct 12, 1971, to Oct 12, 1971, that (I) ~~(we)~~ last sow the deceased olive on Oct 12 1971, ond thot in (my) ~~(our)~~ opinion death occurred an the dote ond hour and from the causes stoted obave, (I) ~~(we)~~ (did) ~~(did not)~~ view the body ofter death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Thomas C Hill Jr | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 10-12-71 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS: Pine Bluff Road Salisbury Md | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/16/71 | 23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cemetery | 23d. LOCATION (City or Town): Salisbury | (County): Wicomico (State): Md. |
| 24. FUNERAL DIRECTOR: Clinton F. Stewart | ADDRESS: Salis Md. | 25a. REC'D BY REGISTRAR DATE: OCT 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R Randall | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16014 16025

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3)
25m-1/70

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Edward L. Crockett | 2a. DATE OF DEATH Month / Day / Year | October 2 1971 |
| 2b. HOUR | 1 P.M. | | |
| 3. SEX | MALE | 4. RACE | White |
| 5. DATE OF BIRTH | Feb. 14, 1906 | 6. AGE (In years last birthday) | 65 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | 65 | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Virginia | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Warehouseman | 12b. KIND OF BUSINESS OR INDUSTRY | Storage Balto. Cold |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Cristfield | 13b. COUNTY | Somerset |
| 13c. CITY OR TOWN | SomersCove | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | |
| 13e. STREET AND NUMBER | 43 Somers Cove | | |
| 14. FATHER'S NAME First / Middle / Last | Henry Crockett | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Sadie ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | no | (If yes give war or dates of service) | none |
| 16b. SOCIAL SECURITY NO. | 214-01-2316 | 17. INFORMANT | Bruce Crockett |
| Address | 168 Langtry Drive | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma of common bile duct — 3 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1561

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 9/24 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Jaundice |
| 20a. AUTOPSY? YES [ ] NO [X] | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/15, 19 71, to 10/2, 19 71, that (I) (we) last saw the deceased alive on 10/2 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | Philip A. Insley Jr. MD | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] |
| 22c. DATE SIGNED | 10/2/71 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | Ph.l.p A. Insley JR | 22e. ADDRESS | Medical Center Salisbuey Md | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | Oct. 5, 1971 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Meadowridge Cemetery | 23d. LOCATION (City or Town) (County) (State) | Washington Blvd. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS | Krause Funeral Home 1216S.Charles St. | 25a. REC'D BY REGISTRAR DATE | OCT 5 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall |

16015

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16026

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR | |
| Rosalee | - | Cronshaw | Oct. | 19, | 1971 | 8:15 | a |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
| female | white | Dec. 6, 1887 | 83 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | Wicomico | | | | Md |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | Pine Bluff State Hosp. | housewife | - | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER | | | |
| Maryland | Caroline | Ridgely | | - | | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | | |
| James | - | Morris | Mary | - | Minner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | | |
| No | - | 220-26-3825A | records of | Pine Bluff State Hospital | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Arteriosclerotic cardiovascular disease | unknown |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that ☒ (this hospital) attended the deceased from July 23, 1971, to Oct. 19, 1971, that ☒ (we) last saw the deceased alive on Oct. 19 1971, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | ☐ | ☒ | ☐ | Oct. 19, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Oct. 21 | Chesterfield | Centreville | Qn. | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lane Funeral Home | Church Hill Md | OCT 22 1971 | Vernon R. Randall |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT. 16016 — 16027

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 28. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 1 and 2 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M-1/70

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Mary | Middle: ELIZABETH | Last: CROPPER | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month 10 Day 10 Year 71 | 2b. HOUR 3:10 P M | | | |
| 3. SEX: F | 4. RACE: AA | 5. DATE OF BIRTH: 5-11-10 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month 10 Day 10 Year 71 | 2d. HOUR M |
| 7a. BIRTHPLACE (State or foreign country): Girdletree | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER: Rt. 1, Box 98 | | | |
| 14. FATHER'S NAME First: William | Middle: John | Last: Purnell | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Stevenson | Last: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Edward Waters | ADDRESS: Rt. 1 Box 52 - Girdletree Md. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
22b. DATE SIGNED: Oct. 12, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 10-16-71 | Cool Spring | Girdletree | Wor. | Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Jolley Funeral Home, Salisbury, Md. | OCT 21 1971 | Vernon R. Randall |

16017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#4, Film G441 10/22/71 kam

# CERTIFICATE OF DEATH

16028

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HERMAN | | Dashield. | 10 08 71 | 4p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| Male | Negro Non-White | 5/5/96 | 75 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S. | MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Wicomico Rehabilitation Center | Farmer & Waterman | Self employed |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Tyaskin | YES ☐ NO ☑ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Joseph | | Dashield | Jane | H. | Nutter |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | WW I | 220-32-0185 | Katie Dashield | Tyaskin, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMATOSIS, METASTATIC — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

185X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF PROSTATE

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8/18, 19 71, to 10/08, 19 71, that (I) (we) last saw the deceased alive on 10/07 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | MD | ☑ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ELIAS LUIS D-DIA | 516-B Camden Ave. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/12/71 | Tyaskin Cem. | Tyaskin, Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| C. G. Pusey | Bivalve, Md. | OCT 14 1971 | Vernon G. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1) 45M - 1-69

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16018 — 16029

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s), page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

| | |
|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | EVELYN / B. / DAVIS |
| 2a. DATE OF DEATH Month / Day / Year | October 24, 1971 |
| 2b. HOUR | 10 P.M. |
| 3. SEX | Female |
| 4. RACE | White |
| 5. DATE OF BIRTH | May 21, 1911 |
| 6. AGE (In years last birthday) | 60 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | |
| IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Virginia |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hosp. |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | -- |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Virginia |
| 13b. COUNTY | Accomack |
| 13c. CITY OR TOWN | New Church |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | |
| 13e. STREET AND NUMBER | R.F.D. 1 |
| 14. FATHER'S NAME First / Middle / Last | Julius / -- / Bailey |
| 15. MOTHER'S MAIDEN NAME First / Middle / Last | Drucilla / -- / Träder |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | No |
| (If yes give war or dates of service) | -- |
| 16b. SOCIAL SECURITY NO. | none |
| 17. INFORMANT Address | W. A. Davis, Sr., New Church, Virginia |

**MEDICAL CERTIFICATION**

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | |
|---|---|
| 19a. DATE OF OPERATION | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES ☑ NO ☐ | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | Yes |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | |
| 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** that (I) (this hospital) attended the deceased from 10/22, 19 71, to 10/24, 19 71, that (I) (we) last saw the deceased alive on 10/24 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

| | |
|---|---|
| 22b. SIGNATURE | W. B. Horner MD |
| DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ |
| 22c. DATE SIGNED | 10/26/71 |
| 22d. PHYSICIAN'S NAME (Type) | W. B. Horner, M.D. |
| 22e. ADDRESS | Salisbury, Maryland 21801 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) (State) |
| Burial | 10-27-1971 | Nelson Cemetery | Accomack | County, Virginia |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| Robert H. Watson | Pocomoke City, Md. | NOV 1 1971 | Vernon B. Randall | |

Robert H. Watson

1 6

16019

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16030

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| MADLYN | VIRGINIA | DENNIS | 10 | 1 | 71 | 745 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN |
|---|---|---|---|---|---|---|---|
| Female | White | 3-25-21 | 50 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S.A. | MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Wicomico Rehab. Center, Booth Street | Cafeteria Employee | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES ☑ NO ☐ | 410 Dover Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Albert | Edward | Galusha | Catherine | Priscilla | Fox |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Husband) | Address |
|---|---|---|---|---|
| No | | | Mr. Mitchell F. Dennis, | same as 13e Salisbury, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Widespread cancer. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Months
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

1991

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9/28/71 19___, to 10/1/71 19___, that (I) (we) last saw the deceased alive on 9/30/71 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| A C Mitchell | MD | ☑ | ☐ | ☐ | 10/1/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. A. C. Mitchell | Fruitland, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 4, 1971 | Springhill Memory Gardens | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, P.A., Salisbury, Md. | OCT 7 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16020 — 16032

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: William | Middle: Francis | Last: Donnelly | 2a. DATE OF DEATH Month: Oct. Day: 25, Year: 1971 | | 2b. HOUR: 11:00 |
| 3. SEX: male | 4. RACE: white | 5. DATE OF BIRTH: Dec. 3, 1896 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): New York | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico | | | Md |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pine Bluff State Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): clerical | 12b. KIND OF BUSINESS OR INDUSTRY: - | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Dorchester | 13c. CITY OR TOWN: East New Market | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: Route 1 21631 | | |
| 14. FATHER'S NAME First: William | Middle: - | Last: Donnelly | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: - | Last: Scalan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service): - | 16b. SOCIAL SECURITY NO.: 088-05-8481A | 17. INFORMANT: records of | Address: Pine Bluff State Hospital | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): malnutrition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. I certify that (I) (this hospital) attended the deceased from Oct. 22, 19 71, to Oct. 25 19 71, that (I) (we) last saw the deceased alive on Oct. 25 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | [ ] | [X] | [ ] | Oct. 26, 1971 |
| 22d. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D. | | | | | 22e. ADDRESS: Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Buried | Oct. 28, 1971 | Calvary Cemetery | Long Island City New York | | N.Y. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John W. Thomas | Thomas Funeral Home 700 Locust St. Cambridge, Md. | OCT 29 1971 | Vernon O. Randall |

VR A15 (4)
45M - 1/69

16

16021

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16033

Item#8, FilmG441 10/29/71 kam

# CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Iva Middle: Lee Last: Douglas | 2a. DATE OF DEATH Month: October Day: 20 Year: 1971 | 2b. HOUR: 8:15 P.M. | |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: May 29, 1924 | 6. AGE (In years last birthday): 47 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Seafood |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Crisfield | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: Somers Cove Apts. | | | |
| 14. FATHER'S NAME First: James Middle: Last: Jackson | 15. MOTHER'S MAIDEN NAME First: Naomi Campbell Middle: Last: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Burnzie Douglas Address: Crisfield Md | |

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19
2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4122

IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

2

22a. **I certify** that (I) (this hospital) attended the deceased from October 20 19 71, to October 20 19 71, that (I) (we) last saw the deceased alive on October 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Felix J. Martin DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ] | 22c. DATE SIGNED: 10/20/71 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS: Deer's Head State Hospital, Salisbury Maryland | |

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/23/71 | 23c. NAME OF CEMETERY OR CREMATORY: Asbury | 23d. LOCATION (City or Town) (County) (State): Crisfield Md. |
| 24. FUNERAL DIRECTOR: Anthony C. Ward Crisfield Md | ADDRESS | 25a. REC'D BY REGISTRAR DATE: OCT 26 1971 | 25b. REGISTRAR'S SIGNATURE: Simon O. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

Items#7a,7b&8 Film#G442
11/8/71 vpw

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16034

1. DECEASED-NAME (Type or Print) First: EDNA Middle: M. Last: BEAUCHAMP ELLIOTT — 16022
2a. DATE OF DEATH: Month OCTOBER Day 24 Year 1971
2b. HOUR: 9:30 A M
3. SEX: FEMALE
4. RACE: W
5. DATE OF BIRTH: MAR. 15, 1888
6. AGE (In years last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE WIFE
12b. KIND OF BUSINESS OR INDUSTRY: HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: Wor.
13c. CITY OR TOWN: OCEAN CITY
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: S. BALTI. AVE.
14. FATHER'S NAME First: JOHN Middle: Last: BEAUCHAMP
15. MOTHER'S MAIDEN NAME First: SALLIE Middle: Last: GRAVENOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): NO
16b. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. CHARLES ELLIOTT OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): palmonary edema
DUE TO, OR AS A CONSEQUENCE OF (b): extensive metastic carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1990
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☑ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Oct 5, 19 71, to Oct 24, 19 71, that (I) (we) last saw the deceased alive on Oct 24 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. B. Horner MD DEGREE — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/26/71
22d. PHYSICIAN'S NAME (Type): W.B. Horner, M.D.
22e. ADDRESS: Kay Drive, Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/27/71
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): BERLIN WOR MD
24. FUNERAL DIRECTOR: Anna A. Burbage
ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE: NOV 1 1971
25b. REGISTRAR'S SIGNATURE: Vernon B. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

16023

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16035

| | |
|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last | Elizabeth N. Evans. |
| 2a. DATE OF DEATH Month Day Year | 10-28-71 |
| 2b. HOUR | 1030A M |
| 3. SEX | Female |
| 4. RACE | White |
| 5. DATE OF BIRTH | 7/17/1885 |
| 6. AGE (In years last birthday) | 86 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | |
| IF UNDER 24 HRS. HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country) | Delaware |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S. |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Nursing Home |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Clerk - Clothing Store |
| 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Md |
| 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Salisbury |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET AND NUMBER | 1013 E. Church St. |
| 14. FATHER'S NAME First Middle Last | George Niblett |
| 15. MOTHER'S MAIDEN NAME First Middle Last | Mary Baker |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | No |
| 16b. SOCIAL SECURITY NO. | 214-10-9757 |
| 17. INFORMANT Address | Mrs Edith White, Salisbury, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | reticulum cell lymphoma. | 4 mos. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

2000

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | |
|---|---|
| 19a. DATE OF OPERATION | 8/22/71 |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Biopsy. |
| 20a. AUTOPSY? YES ☐ NO ☒ | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | |
| 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 8/26, 1969, to 10/26, 1971, that (I) (we) last saw the deceased alive on 10/21 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | |
|---|---|
| 22b. SIGNATURE | [signature] |
| DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | |
| 22c. DATE SIGNED | 10/ |
| 22d. PHYSICIAN'S NAME (Type) | Earl Beardsley |
| 22e. ADDRESS | Salisbury, Md. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial |
| 23b. DATE | 10/29/71 |
| 23c. NAME OF CEMETERY OR CREMATORY | St. Stephens Cem. |
| 23d. LOCATION (City or Town) (County) (State) | Delmar, Del. |
| 24. FUNERAL DIRECTOR ADDRESS | C. G. Messick, Bivalve, Md. |
| 25a. REC'D BY REGISTRAR DATE | NOV 1 1971 |
| 25b. REGISTRAR'S SIGNATURE | Vernon B. Bradley |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

12 16024

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#4,5,FilmG441 10/18/71 kam

# CERTIFICATE OF DEATH

16036 JST

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| ELEANOR | F. | FLETCHER | 10 | 3 | 71 | 12 55 A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
| FEMALE | WW Negro | 11/02/1914 | 56 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH | | | | |
| MARYLAND | U.S. | | WICOMICO Md. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| SALISBURY | WIC REHAB CENTER | TEACHERS AID | EDUCATION | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER | | | |
| MARYLAND | WORCESTER | POCOMOKE | | P.O. BOX 87 | | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | | |
| Robert | Waters | | Josphine | ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | | | |
| NO | 215-22-8926 | Freddrick Fletcher | Pocomoke, Md | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMATOSIS, METASTATIC — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO, OR AS A CONSEQUENCE OF

(b) CARCINOMA OF LUNG

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) opinion death occurred on the date and hour ond from the causes stated above, (I), (we) (did) (did not) view the body ofter death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Elias L. D. Dia | MD | ☒ | ☐ | ☐ | 10/06/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ELIAS LUIS D. DIA MD | 516-B WEDGELO AVE, SALISBURY, MD. 21801 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 10-8-71 | Star of The EAST | ACCOMAC-ACCOMACK, VA. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Whorton & Burge | New Church, Va. | OCT 13 1971 | Thomas B. Rand M.D. |

VR A15 (4) 45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

16025

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16037

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR A13. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: ORAN | Middle: SPENCER | Last: FLETCHER JR. | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ | Month Day Year: 10-6-71 | 2b. HOUR: 2 A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: March 30/28 | 6. AGE (In years last birthday): 43 YRS. | IF UNDER 1 YEAR: MONTHS 6 DAYS 06 | IF UNDER 24 HRS: HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year: Oct. 6 1971 | 2d. HOUR: 7:45 A M |
| 7a. BIRTHPLACE (State or foreign country): Wicomico Co. Md | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): North Salisbury Blvd Tavern | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Truck Driver-Laborer | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 221 Cherry-way | | | |
| 14. FATHER'S NAME First Middle Last: ORAN SPENCER FLETCHER | | 15. MOTHER'S MAIDEN NAME First Middle Last: MARY ESTHER JENKINS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 218-20-3778 | 17. INFORMANT ADDRESS: Mrs. Mary E. Dryden (mother) 221 Cherry-way Salisbury, Md. 21801 | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bullet Wound of Brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

955X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ | |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 2 Oct. 6, 71 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Self-inflicted. | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Tavern | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: North Salisbury Blvd. Salisbury (Wico Co) Md. | |

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Earl L. Royer

ADDRESS (Street, city, town, or county): 409 Camden Ave. Salisbury, Md. 21801

22b. DATE SIGNED: Oct. 8 /1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 9/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | 23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR: HOLLOWAY FUN'L HOME P.A. | ADDRESS: SALISBURY, MD. | 25a. REC'D BY REGISTRAR DATE: OCT 12 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

VR A15ME (5) 8M-1/70

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16026 16038

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2o. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Charles | E. | Garrison | October | 26 | 1971 | 1:20 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Negro | Dec. 2, 1902 | 68 YRS. | | |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Laborer | Constructio |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Cecil | Cecilton | YES ☒ NO ☐ | Bohemia Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Charles | | Garrison | Bessie | | Thompson |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No. | | 212-16-1082 | William Garrison, Cecilton, Md. 21913 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Carcinoma of the prostate with bone — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO, OR AS A CONSEQUENCE OF metastasis.

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 185X

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21o. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22o. **I certify** that (I) (this hospitol) ottended the deceased from May 19, 19 71, to October 26, 19 71, thot (I) (we) last saw the deceased alive an October 26 19 71, and that in (my) (our) opinion death occurred an the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Felix J. Martin | | ☐ | ☐ | ☒ | 10/26/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Felix J. Martin, M.D. | Deer's Head State Hospital, Maryland Salisbury |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 30, 1971 | Cecilton Cemetery | Cecilton, Cecil, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Edward Fellows & Son, Millington, Md. | NOV 1 1971 | Vernon B. Bardell |

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16027 16039

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| GRAHAM | — | Gunby Jr | 10 10 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| MALE | White | 5-17-1908 | 63 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| MARYLAND | SALISBURY NURSING HOME | L. WINGUNBY | HARDWARE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | YES ☒ NO ☐ | 113 WALNUT ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GRAHAM | | GUNBY, SR | VIRGINIA | | GORDY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or date of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WWII | 214-10-8121 | MRS JOHN BRITTINGHAM | SALISBURY, MD |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 10/10, 1971, that (I) (~~we~~) last saw the deceased alive on 10/7/1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Earl C. Bozeday | | | | | 10/12/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| EARL C. BOZEDAY M.D. | SALISBURY MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 10-12-1971 | PARSONS CEMETERY | SALISBURY, WIC. MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hill-Baker-Bounds | SALISBURY, MD. | OCT 15 1971 | Vernon O. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 7-69

1 R 16028

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16040

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: CHARLES | Middle: A | Last: HARMON | 2a. DATE OF DEATH Month: October | Day: 23 | Year: 1971 | 2b. HOUR: 8 00 P.M. |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: May 10, 1910 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Construction | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET AND NUMBER: 201-A Commerce St. | | | |
| 14. FATHER'S NAME First: Arthur | Middle | Last: Harmon | 15. MOTHER'S MAIDEN NAME First: Beulah | Middle | Last: Johnson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: Unknown | 17. INFORMANT Address: Mrs Delores Waters, Snow Hill, Md. | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

582 X

IMMEDIATE CAUSE (a): Uremia with Acidosis

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Renal Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** thot (I) (~~this hospital~~) attended the deceased from Oct 20, 1971, to Oct 23 1971, thot (I) (~~was~~) last saw the deceased alive an Oct 23 1971, and that in (my) (~~our~~) opinian death occurred on the dote and haur and from the causes stated obave, (I) (~~was~~) (did) (~~did not~~) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Thomas C Hill Jr | MD DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: Oct 23, 1971 |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS: Pine Bluff Road, Salisbury Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10-26-71 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Wesley | 23d. LOCATION (City or Town): Snow Hill | (County) (State): Md. |
| 24. FUNERAL DIRECTOR: Vernon F. Kenny | ADDRESS: Snow Hill Md | 25a. REC'D BY REGISTRAR DATE: OCT 26 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 M 25m-1770

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16029

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

17635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Maria | Taylor | Hill | 10 | 16 | 71 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Negro | 4-1-03 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Snow Hill | U.S.A | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Domestic | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☒ NO ☐ | 305 Hill Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Henry | | Taylor | Lizzie | ? | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | 215-18-4110 | Raymond Bratten | Rt #2 Parsonsburg Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/4, 19 71, to 10/24, 19 71, that (I) ~~(we)~~ last saw the deceased alive on 10/25, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE Sally Bunting DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 10/26/71

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-28-71 | Hutts Chapel | Snow Hill Worc. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Dolley Funeral Home | Jersey Rd. Salis. Md. | NOV 12 1971 | Vernon O. Randall |

VR A15(4) 25m-1/70

1

16030

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16042

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Hazel | Middle: | Last: Hollis | 2a. DATE OF DEATH Month: 10 Day: 11 Year: 1971 |
| 2b. HOUR: 8:00 A M | | | |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: AUG. 15, 1911 | 6. AGE (In years last birthday): 60 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): md | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABOR | 12b. KIND OF BUSINESS OR INDUSTRY: VARIOUS |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Caroline | 13c. CITY OR TOWN: Marydel | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: R.F.D. | | | |
| 14. FATHER'S NAME First: William | Middle: | Last: Hollis | 15. MOTHER'S MAIDEN NAME First: MAGGIE | Middle: | Last: UNK |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MRS. MAGGIE Seals Address: BARCLAY, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute coronary thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recurrent cerebral vascular accidents.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that ☒ (this hospital) attended the deceased from 5/3, 19 71, to 10/11, 19 71, that ☒ (we) last saw the deceased alive on 10/11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. H. Winnacott M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 10/12/71

22d. PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BUR. | 23b. DATE: 10/16/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery | 23d. LOCATION (City or Town): Marydel | (County) | (State): Md. |
| 24. FUNERAL DIRECTOR: Kenneth Wells | ADDRESS: Chestertown, Md | 25a. REC'D BY REGISTRAR DATE: OCT 19 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | | |

VR A15 (M) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16031

# CERTIFICATE OF DEATH

16043

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Albert | Louis | Hudson | Oct. 20, 1971 | 7:37 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| male | negro | March 18, 1896 | 75 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Pine Bluff State Hosp. | hospital attendant | - |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES [X] | 411 E. Booth Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Fred | - | Hudson | Laura | - | Dashiell |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | W. W. I | 214-32-0537 | records of | Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4124 | IMMEDIATE CAUSE (a) cerebral vascular accident | unknown |
| | DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease | |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from Aug. 27, 19 71, to Oct. 20 19 71, that (I) (we) last saw the deceased alive on Oct. 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | [ ] | [X] | [ ] | Oct. 21, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct 23-71 | Glass Hill Cem | Parsonsburg Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Booker M West | | OCT 26 1971 | Vernon C. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16032

# CERTIFICATE OF DEATH

16045

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Albury | Lemuel | Hull | Oct. 14, 1971 | 1:50 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
|---|---|---|---|---|---|
| male | negro | May 6, 1898 | 73 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Pine Bluff State Hosp. | farmer | farm |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Quantico | | Route 1, Box 112 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Handy | - | Hull | Sarah | - | Moore |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | - | 220-28-4209 | records of | Pine Bluff State Hospital |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
1621
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that ☒ (I) (this haspital) attended the deceased from Oct. 13, 1971, to Oct. 14, 1971, that ☒ (I) (we) last saw the deceased alive an Oct. 14 19 71 and thot in (my) (our) opinion death occurred on the date and hour and fram the causes stated above, ☒ (we) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☒ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | | | | Oct. 14, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 10/19/71 | Odd Fellows Cem. | Westquin | | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Messick, Bivalve, Md. | | OCT 19 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
45M - 1/69

1603P

1

16033

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16046

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Bertha Grace Middle: Lost: Jessop | 2a. DATE OF DEATH Month Day Year: October 27 1971 | 2b. HOUR M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: March 18, 1906 | 6. AGE (In years last birthday) 65 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: WOR. | 13c. CITY OR TOWN: Ocean City | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] |
| 13e. STREET AND NUMBER: 105 70th St. Ocean City, Md. | | | |
| 14. FATHER'S NAME First Middle Lost: Albert W. Hyser | 15. MOTHER'S MAIDEN NAME First Middle Lost: Bertha | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: William O. Jessop 105 70th St. Ocean City, Md. | |

80 23 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Bronchogenic Ca. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

1621

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

2

22a. I certify that (I) (this hospital) attended the deceased from 9/27/71, 19 71, to 10/27/71, 19 71, that (I) (we) last saw the deceased alive on 10/27/ 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/1/71 | 23c. NAME OF CEMETERY OR CREMATORY: My. Olivet | 23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland |
| 24. FUNERAL DIRECTOR: Witzke, 1630 Edmondson Avenue | ADDRESS: 21228 | 25a. REC'D BY REGISTRAR DATE: OCT 28 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

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16034

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16047

Item#23b, Film 6441 10/14/71 kam

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| George | T. | Johnson | October 1 1971 | 10 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 10/27/1878 | 92 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WORCESTER CO. | U.S.A. | NEVER MARRIED X | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head Hospital | RETIRED LOBER | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Crisfield | YES / NO | |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| THOMAS ALFORD JOHNSON | NANCY JANE BROWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 218-05-8793=a | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES / NO X | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING / | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 1/23, 1967, to 10/1/, 1971, that (I) (we) last saw the deceased alive on Oct. 1 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|
| Felix J. Martin | STAFF PHYS. X | 10/1/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Felix J. Martin, M.D. | Deer's Head Hospital; Salisbury, Md. 21801 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 10/5/1971 | oliver cemetery | EAST PRINCESS ANNE, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| LEVIN R. WILSON PRINCESS ANNE, MD. | OCT 5 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

16035

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16048

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| VICTOR | | JOHNSON |

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month 10 Day 11 Year 19 71 — 2b. HOUR 4:20 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN |
|---|---|---|---|---|---|---|---|
| M | AA | 11-13-65 | 5 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month 10 Day 11 Year 19 71 — 2d. HOUR 4:28 P.M.

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| Phila | U.S.A | MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | DOA Peninsula General | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES [ ] NO [ ] | 714 Lake St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Leroy | Milbourne | | Virginia | | Johnson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Virginia Macy | 180 Kilpatrick St. Salisbury Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Crushed Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 4:20 P.M. 10-11-71 | Gas truck backed over child. |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | driveway | Rose St., Salisbury, Wicomico, Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Earl L. Royer M.D. — CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type) Earl L. Royer, M.D. ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED Oct. 15, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-16-71 | Green Acres | Salisbury Wico. Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Jolley Funeral Home, Salisbury, Md. | OCT 21 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(3) 8M-1/70

1

16036

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16049

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
| DOLA | L. | JONES | OCTOBER 22, 71 | 9:00 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | NEGRO | FEB 12-1921 | 50 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | HOUSEHOLD | HOUSEHOLD |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | Som. | DAMES QUARTER | YES ☒ NO ☐ | MAIN ROAD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| LUTHER | | JONES | RUTH | | ROXBURY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | NONE | HILDA JONES | DAMES QUARTER MD. 21820 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Terminal Carcinoma

1991

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. I certify that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Gladys M. Allen | | ☐ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| BURIAL | 10/24/71 | MACEDONIA CEMETERY | DAMES QUARTER Som. MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Leroy Webster | Princess Anne Md. | OCT 29 1971 | Vernon O. Randall |

VR AN 5 (4)
25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

16037 16050

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARGARET | INEZ | KEATING | October 21 1971 | 11:40 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| Female | White | April 7, 1885 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Kentucky | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | House work | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Princess Anne | YES ☐ NO ☒ | R.D. 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | | Rose | Mary | | Riessen |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) | Address |
|---|---|---|---|---|
| No | | 212-12-6765D | Mrs. Margaret K. Schwartz, | Princess Anne, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4274
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Gangrene of R leg | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Embolus from Heart | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Atrial fibrillation | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
Stroke affecting L. side. ASCV Disease.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/22/71, 19__ to 10/21/71, 19__, that (I) (we) last saw the deceased alive on 10/20/71, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | October 22/1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. O. J. Burton | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | October 25, 1971 | Wicomico Memoiral Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, P. A., Salisbury, Md. | OCT 26 1971 | Vernon R. Randall |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16038

# CERTIFICATE OF DEATH

16051

| 1. DECEASED-NAME (Type or print) First | Middle | Lost |
|---|---|---|
| Abraham | H. | King |

| 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|
| October | 25 | 1971 | 10:15 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Negro | 3-25-03 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| D. C. | U.S.A. | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head Hospital | Laborer | None |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☐ | 901 West Road |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Tart K. | King | | Anna | Steele | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | 218-30-4863 | Josephine King | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Carcinoma of liver with metastasis to transverse colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 1978

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

Cirrhosis of the liver

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING (If either, notify medicol examiner) | UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify thot (I) (this hospitol) attended the deceosed from 10/18, 19 71, to 10/25, 19 71, that (I) (we) last saw the deceased alive an 10/25 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Felix J. Martin | | ☐ | ☐ | ☒ | 10/25/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Felix J. Martin, M.D. | Deer's Head Hospital; Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Buried | 10-30 71 | Green Acres Memory Pk. | Salisbury | Wico. | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Bacon & West | | OCT 28 1971 | Vernon A. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-11/70

1

16039

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16052

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Ethel Middle: Lost: Lewis | 2a. DATE OF DEATH Month: October Day: 12 Year: 1971 | 2b. HOUR: 2:30 A.M. | |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: Nov. 14, 1909 | 6. AGE (In years last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Georgia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housework | 12b. KIND OF BUSINESS OR INDUSTRY: Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Caroline | 13c. CITY OR TOWN: Federalsburg | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First: Benjamin Middle: Lewis Lost: | 15. MOTHER'S MAIDEN NAME First: Mary Middle: (maiden name unknown) Lost: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: Unknown | 17. INFORMANT Address: Mrs. Mary Wilcox, Great Neck, New York | |

91 05 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary occlusion | -- |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertensive arteriosclerotic cardiovascular disease | Years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral thrombosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

2

22a. **I certify** that (I) (this hospital) attended the deceased from Sept. 27, 19 71, to Oct. 12, 19 71, that (I) (we) last saw the deceased alive an Oct. 12 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: W. Maldve, MD DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 10/12/71 | |
| 22d. PHYSICIAN'S NAME (Type): Leonid V. Maldve, M.D. | 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland | |

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 16, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Federal Hill Cemetery | 23d. LOCATION (City or Town) (County) (State): Federalsburg, Maryland |
| 24. FUNERAL DIRECTOR: Frame Framptom Jr. ADDRESS: Framptom Funeral Home, Federalsburg, Maryland | 25a. REC'D BY REGISTRAR DATE: OCT 19 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

16040

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16053

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ARTHUR | Middle: L. | Last: MARSHALL | 2a. DATE OF DEATH: Month: October | Day: 26 | Year: 1971 | 2b. HOUR: 8A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: May 10, 1899 | 6. AGE (In years last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Seafood Dealer | 12b. KIND OF BUSINESS OR INDUSTRY: Seafood | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Crisfield | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 72 Maryland Ave. | | | |
| 14. FATHER'S NAME First: Samuel | Middle: - | Last: Marshall | 15. MOTHER'S MAIDEN NAME First: Margaret | Middle: - | Last: Smith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service): None | 16b. SOCIAL SECURITY NO.: 220-32-0447 | 17. INFORMANT: Mrs. Hazel Marshall, Same as 13. | Address: abcde | | | |

**MEDICAL CERTIFICATION**

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cereval Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9/27/71

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerotic Heart Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. | City or Town | County | State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 9/27, 19 71, to Oct. 26, 19 71, that (I) (we) last saw the deceased alive on Oct. 26 19 71, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: David J. Gilmore, M.D. — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): David J. Gilmore, M. D. — 22e. ADDRESS: Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct 29, 1971 | St. Paul's Cemetery | Marion, Somerset, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Bradshaw & Sons, Crisfield, Md. 21817 | | NOV 1 1971 | Vernon B. Randall |

VR A15-(4) 25m-1-70

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

16041

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16054

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DH3. Page may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: DOROTHY | Middle: MAE | Last: MARVEL | 2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month Day Year: 10-6-71 19 | 2b. HOUR: 2 A M | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: 4-10-23 | 6. AGE (In years last birthday): 48 YRS. IF UNDER 1 YEAR: MONTHS 5 DAYS 26 IF UNDER 24 HRS.: HOURS MIN | 2c. DATE PRONOUNCED DEAD Month 10 Day 6 Year 71 | 2d. HOUR: 7:45 A M | |
| 7a. BIRTHPLACE (State or foreign country): DELAWARE | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Tavern N. Salisbury Blvd. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): barmaid | 12b. KIND OF BUSINESS OR INDUSTRY: tavern | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: N. Salisbury Blvd. | | |
| 14. FATHER'S NAME: First JOHN | Middle | Last SIMPLER | 15. MOTHER'S MAIDEN NAME: First LOUISE | Middle MAE | Last (UNK) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mrs. Louise Ann Shufelt - Daughter Rehoboth, Delaware | | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bullet Wound of Brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

965X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ | |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. ☒ P.M. 2 10-6-71 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Shot during altercation. | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): tavern N. | 21f. LOCATION Street or R.F.D. No.: Salis. Blvd., | City or Town: Salisbury, | County: Wicomico, | State: Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: Oct. 8, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 9/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Dagsboro Cemetery | 23d. LOCATION (City or Town) (County) (State): Dagsboro, Delaware | |
| 24. FUNERAL DIRECTOR ADDRESS: Holloway Funeral Home, Salisbury, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 12 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon B. Randall | | |

VR A15ME (5) 8M-1/70

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 hours after death.

VR A15 (a)
45M - 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16042 — 16055

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Clarence | Middle: Earl | Last: McDaniel | 2a. DATE OF DEATH Month: October | Day: 31 | Year: 1971 |
| 2b. HOUR | 6:05 M | | | | | |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH | July 22, 1896 | 6. AGE (In years last birthday) 75 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Deer's Head State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Waterman | 12b. KIND OF BUSINESS OR INDUSTRY: Seafood |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Worcester | 13c. CITY OR TOWN | Pocomoke | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ |
| 13e. STREET AND NUMBER | 205 Broad Street | | | | | |
| 14. FATHER'S NAME First | Lora | Middle: H. | Last: McDaniel | 15. MOTHER'S MAIDEN NAME First | Sallie | Middle: --- Last: Riggin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | yes | (If yes give war or dates of service) | WW I | 16b. SOCIAL SECURITY NO. | 217-14-8543 | 17. INFORMANT Address: Mrs Blanche McDaniel, same 13a,b,c,e. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcimoma of the Lung, Metastitic to the Brain | 1969 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | with Right Plural Effusion | |
| | Chronic Brain Syndrone sec. to (a) | 1969 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Pneumonia - Bronchopneumonia | 1 month |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from Dec. 16, 19 71, to Oct. 31, 19 71, that (I) (we) last saw the deceased alive on Oct. 31, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | John J. Calarco M.D. | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☒ |
| 22c. DATE SIGNED | 10-31-71 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | John J. Calarco, M.D. | 22e. ADDRESS | Deer's Head State Hospital - Salisbury, Maryland | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | 11-2-1971 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~ First Baptist |
| 23d. LOCATION (City or Town) (County) (State) | Pocomoke City-Wor-Md. | | | |
| 24. FUNERAL DIRECTOR | Robert N. Watson | ADDRESS | Pocomoke City, Md. | |
| 25a. REC'D BY REGISTRAR DATE | NOV 9 1971 | 25b. REGISTRAR'S SIGNATURE | Vernon A. Randall | |

Robert N. Watson

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16043

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

17649

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Granville Francis McGregory | 2a. DATE OF DEATH Month / Day / Year | Oct. 31 1971 | 2b. HOUR | 4:31 P.M. |
| 3. SEX | male | 4. RACE | negro | 5. DATE OF BIRTH | Jan. 30, 1905 |
| 6. AGE (In years last birthday) | 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Wicomico Md | | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Pine Bluff State Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | laborer |
| 12b. KIND OF BUSINESS OR INDUSTRY | - | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Wicomico | 13c. CITY OR TOWN | Salisbury |
| 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | | 13e. STREET AND NUMBER | 401 Keene Ave. | | |
| 14. FATHER'S NAME First / Middle / Last | Frank - McGregory | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Eleanor - Smack | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | No | (If yes give war or dates of service) | - | 16b. SOCIAL SECURITY NO. | 221-24-8531 |
| 17. INFORMANT | records of | Address | Pine Bluff State Hospital | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cerebral vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. I certify that ☒ (this hospital) attended the deceased from Oct. 29, 1971, to Oct. 31, 19 71, that ☒ (we) last saw the deceased alive on Oct. 31 19 71 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) ☐ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. P. Ritchings | | ☐ | ☒ | ☐ | Nov. 1, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. P. Ritchings, M.D. | Pine Bluff State Hospital |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11-6-71 | Evergreen | Berlin Worc. Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Valley Memorial Chapel - Jersey Rd. Salisbury, Md. | NOV 12 1971 | Vernon R. Randall |

VR A15 M
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

Item#2a,FilmG441 10/28/71 kam

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16044

16056

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the State Department of Health and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA-3. Pages must be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(3) 8M-1/70

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: RAYMOND | Middle: L. | Last: MELICK | 2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] | Month: Oct. | Day: 17 | Year: 1971 |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: July 12, 1897 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month: October | Day: 17 | Year: 19 71 |
| 7a. BIRTHPLACE (State or foreign country): New Jersey | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: WICOMICO | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Wicomico Rehabilitation Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auto Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: 518 Pine Bluff Road | | | |
| 14. FATHER'S NAME: First: Leonard | Middle: | Last: Melick | 15. MOTHER'S MAIDEN NAME: First: Mary | Middle: Josephine | Last: Baker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes give war or dates of service): WW I | 16b. SOCIAL SECURITY NO.: 218-24-3936 | 17. INFORMANT (Wife) ADDRESS: Mrs. Amanda D. Melick, Salisbury, Maryland same as 13e | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109 IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Factors Arteriosclerosis.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] | |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 10-1 1971 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell from Ladder | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home | 21f. LOCATION Street or R.F.D. No.: 518 Pine Bluff. Pl | City or Town: Sbc. | County: | State: Md |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Philip A Insley M.D.

EXAMINER'S NAME (Type): Dr. Philip A. Insley

ADDRESS (Street, city, town, or county): 116 E. Main St., Salisbury, Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: October 19/1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 20, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | 23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME, P.A., Salisbury, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | | |

1

16045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16057

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Thyra — Middle — Last Molina

2a. DATE OF DEATH: Month 10 Day 15 Year 71

2b. HOUR: 3:54 PM

3. SEX: Female

4. RACE: WHITE

5. DATE OF BIRTH: FEB 6, 1903

6. AGE (In years last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS — DAYS
IF UNDER 24 HRS.: HOURS — MIN.

7a. BIRTHPLACE (State or foreign country): SWEDEN

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Wicomico Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: RFD 2 Zion Rd Box 498

14. FATHER'S NAME First: FRANZ Middle: AKESSON Last:

15. MOTHER'S MAIDEN NAME First: LOUISA Middle: Unknown Last:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 209-01-2963

17. INFORMANT: MANUEL MOLINA, Address: Same as (13E)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma breast
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
174X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** thot (I) (this hospitol) ottended the deceased from 9/26, 1971, to 10/15, 1971, thot (I) (we) last saw the deceased alive on 10/15 1971, ond thot in (my) (our) opinion death occurred on the dote and hour ond from the causes stated obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 10/15/71

22d. PHYSICIAN'S NAME (Type): Edward K. Toomey M.D.

22e. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE: 10-16-1971

23c. NAME OF CEMETERY OR CREMATORY: W. Wm Lee Crematory

23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR ADDRESS: Hill-Baker-Bounds Funeral Home, Salisbury Md.

25a. REC'D BY REGISTRAR DATE: OCT 18 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16046 16058

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: GLADYS | Middle: F. | Last: PAYNE | 2a. DATE OF DEATH: Month October Day 4 Year 1971 | 2b. HOUR: 17 M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Feb. 14, 1901 | 6. AGE (In years last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: -- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: R.F.D. 2 | | |
| 14. FATHER'S NAME First: Frank | Middle: -- | Last: Figgs | 15. MOTHER'S MAIDEN NAME First: Mae | Middle: -- | Last: Callahan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes give war or dates of service): -- | 16b. SOCIAL SECURITY NO.: 215-38-1809 | 17. INFORMANT: John W. Payne, | Address: same 13a,b,c,e. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from 9-29, 19 71, to 10-4, 19 71, that (I) (we) last saw the deceased alive on 10-4 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Wilber R. Ellis, Jr., M.D. | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 10-5-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Wilber R. Ellis, Jr., M.D. | Kay Drive, Salisbury, MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-6-1971 | Remson Methodist | Worcester County, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert H. Watson | Pocomoke City, Md. | OCT 12 1971 | Vernon G. Randall |

Robert H. Watson

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16047

# CERTIFICATE OF DEATH

16059

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Ruth | Elizabeth | Pilchard | October 21 1971 | 3 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | April 22, 1884 | 87 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Housewife | -- |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Pocomoke | | Sixth Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Samuel | -- | Matthews | Elizabeth | -- | Kelley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | -- | 216-54-8979 | Mrs Roy Mason, same 13a,b,c,e. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 Da

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10-1, 19 71, to 10-21, 19 71, that (I) (we) last saw the deceased alive on 10-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wilbur R. Ellis | | ☐ | ☑ | ☐ | 10 27 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Wilbur R. Ellis, M.D. | Kay Drive, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-25-1971 | Goodwill Methodist | Pocomoke City-Wor.-Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Robert H. Watson Pocomoke City, Md. | OCT 27 1971 | Vernon P. Randall |

Robert H. Watson

VR A15-4
25m-1/70

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

16048

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16060

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

| | First | Middle | Last |
|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | ELIZABETH | | POMPEY |

2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 10 Day 8 Year 19 71 — 2b. HOUR 10:10 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | IF UNDER 1 YEAR: DAYS | IF UNDER 24 HRS.: HOURS | IF UNDER 24 HRS.: MIN. |
|---|---|---|---|---|---|---|---|
| F | AA | 9-13-06 | 65 YRS. | | | | |

2c. DATE PRONOUNCED DEAD: Month 10 Day 8 Year 19 71 — 2d. HOUR M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| Va. | U.S.A. | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | DOA Peninsula General | Laborer | Farm |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Worcester | Pocomoke | YES ☐ NO ☒ | Rt. 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Unknown | | | Unknown | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Lena Martin | 6th St. Pocomoke, Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Concussion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Fractures, both Lower Extremities — minutes

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. 8147

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR AM/PM | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | 9:27 P.M. 10-8-71 19 | Pedestrian struck by vehicle. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | highway | Rt. 364, ½ mi. east of | Pocomoke, | Wor., | Md |

22a. **I certify** that I took charge of the remoins described above, held on Autapsy ☐, Inspection ☒, Inquiry ☒, and in my apinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED Oct. 12, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 10-18-71 | Jerusalem Cem. | Temperanceville | Accomack | Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Wharton & Savage, New Church, Va. | OCT 21 1971 | Vernon R. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16049

16061

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Physician's Name and Address in Item 19. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 to be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: JAMES | Middle: LAWRENCE | Last: POMPEY | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ | Month: 10 | Day: 13 | Year: 71 | 2b. HOUR: 4:15 P.M. |
| 3. SEX: M | 4. RACE: AA | 5. DATE OF BIRTH: 9-6-06 | 6. AGE (In years last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month 10 Day 13 Year 1971 | 2d. HOUR: " M |
| 7a. BIRTHPLACE (State or foreign country): Unknown | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Farm | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Route 1 | | | |
| 14. FATHER'S NAME First: Unknown | Middle | Last | 15. MOTHER'S MAIDEN NAME First: Unknown | Middle | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 212-26-1405 | 17. INFORMANT: Hospital Record | ADDRESS | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sub-dural Hematoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Multiple Fractures — 5 days

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8147

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Manth, Day, Yeor HOUR AM ☐ PM ☒: 9:27 P.M. 10-8-71 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.): Pedestrian struck by vehicle. |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Highway | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Rt. 364, ½ mi. east of Pocomoke, Wor., Md |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: Oct. 15, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10-20-71 | Jerusalem Cem. | Temperanceville Accomack Va. |

24. FUNERAL DIRECTOR ADDRESS: Sam Savage Funeral Home, New Church, Va.

25a. REC'D BY REGISTRAR DATE: OCT 26 1971

25b. REGISTRAR'S SIGNATURE: James B. Rendle

19

16050

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

16062

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MINNIE | CLEMENT | RICHARDSON | October 11 1971 | 7:30AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | October 28, 1901 | 69 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Public School Teacher | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Willards | | ------ |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Wilfred | R. | Jester, Sr. | Ida | | Clement |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) Address |
|---|---|---|
| No | 219-36-7280 | Mrs. Jane R. Lewis, Ocean City, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis Abdomen Source Stomach Primary — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6-8 months
1950
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natity medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William B Long | M.D | ☒ | ☐ | ☐ | October 12/1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. William B. Long | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 13, 1971 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND | OCT 15 1971 | Vernon R. Randall |

1

16051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16063

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| William | | Rochester | Oct. | 8 | 71 | 9:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN |
|---|---|---|---|---|---|---|---|
| Male | Negro | 3/17/1899 | 72 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S.A | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Laborer | Various |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Queen Anne | Chestertown | YES ☐ NO ☒ | R.F.D. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Unk | | | Harriett E | | Rochester |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | — — | O.T.'s Rochester | Phila, Pa. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4123 IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Renal failure

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from October 4, 1971, to Oct. 8, 1971, that (I) (we) last saw the deceased alive on Oct. 8, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Felise I. Martin | | ☐ | ☐ | ☒ | Oct. 8, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Felix Martin M.D. | Deer's Head State Hospital, Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | 10/13/1971 | Rochester Cem. | Ingleside | Q.A | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Kenneth Wolfe | Chestertown, Md | OCT 26 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 45M - 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16052 16064

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Ollie | Middle: J. | Lost: JACKSON Russell | 2a. DATE OF DEATH Month: 10 | Day: 25 | Year: 71 | 2b. HOUR: 2 55 PM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: MARCH 3 1890 | 6. AGE (In years last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS — DAYS — | IF UNDER 24 HRS.: HOURS — MIN. — | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ~~DORCHESTER~~ WICOMICO Md. | | | | |
| 10. CITY OR TOWN OF DEATH: SALISBURY | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Salisbury Nursing | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): OWNER PLUMBING SUPPLY | 12b. KIND OF BUSINESS OR INDUSTRY: PLUMBING | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: DORCHESTER | 13c. CITY OR TOWN: GALESTOWN | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET AND NUMBER: MAIN STREET | | | |
| 14. FATHER'S NAME First: WILLIAM | Middle: FRANKLIN | Lost: RUSSELL | 15. MOTHER'S MAIDEN NAME First: MARTHA | Middle: RUSSELL | Lost: ROSSELL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ~~YES~~ NO | (If yes give war or dates of service): WW I | 16b. SOCIAL SECURITY NO.: 218-07-6219 | 17. INFORMANT: HELEN DIXON RUSSELL | Address: RD 3 BOX 197 GALESTOWN, MD. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1wk.
DUE TO, OR AS A CONSEQUENCE OF (b): generalized arteriosclerosis — yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical exominer) UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/22, 19 71, to 10/25, 19 71, that (I) (we) last saw the deceased alive on 10/24, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | ☒ | ☐ | ☐ | 10/26/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| [illegible] | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | OCT 28, 1971 | GALESTOWN CEMETERY | GALESTOWN, | | MARYLAND |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| PAYNTER M. WATSON - SEAFORD, DEL. | | NOV 8 1971 | Vernon R. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16053

# CERTIFICATE OF DEATH

16065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Isaac | Middle: | Lost: Ryans | 2a. DATE OF DEATH Month: October Day: 20 Year: 1971 |
| 2b. HOUR: 10:3[illegible] | | | |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: July 15 1882 | 6. AGE (In years last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Md | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Deer's Head Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Janitor | 12b. KIND OF BUSINESS OR INDUSTRY: school |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Caroline | 13c. CITY OR TOWN: Hillsboro | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: |
| 14. FATHER'S NAME First: Wesley | Middle: | Lost: Rynes | 15. MOTHER'S MAIDEN NAME First: Jane | Middle: | Lost: Young |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: Barton Butler, Hillsboro, Md. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of prostate with extensive bony metastases
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

185X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a)
Arteriosclerotic heart disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that ☒ (this hospitol) attended the deceased from 3/17, 19 71, to 10/20, 19 71, thot ☒ (we) last saw the deceased alive on Oct. 20 19 71, and thot in ~~(my)~~ (our) opinion deoth occurred on the date ond haur and from the causes stated above, ☒ (we) (did) ~~(did not)~~ view the body after deoth.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE (DEGREE): C.H. Winnacott M.D. | ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 10/20/71 | |
| 22d. PHYSICIAN'S NAME (Type): C.H.Winnacott, M.D. | 22e. ADDRESS: Deer's Head Hospital; Salisbury, Md. 21801 | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 23, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Sandtown | 23d. LOCATION (City or Town) (County) (State): Hillsboro, Md. |
| 24. FUNERAL DIRECTOR: Charles Moore | ADDRESS: Denton Md | 25a. REC'D BY REGISTRAR DATE: NOV 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Vandall |

VR A15-(4)
25m-1170

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16054 — 16066

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: LEO | Middle: JOHN | Last: SCHAEFER | 2a. DATE OF DEATH Month: OCTOBER Day: 4 Year: 1971 | 2b. HOUR: 5 A. M | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: MAY 19, 1915 | 6. AGE (In years last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): CANADA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WOR | 13c. CITY OR TOWN: OCEAN CITY | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First: CONRAD | Middle | Last: SCHAEFER | 15. MOTHER'S MAIDEN NAME First: EMMA | Middle | Last: SCHAEFER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WORLD W2 | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MRS. LEO J. SCHAEFER | Address: OCEAN CITY MD | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of Liver
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5719
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I **certify** that (I) (this hospital) attended the deceased from 10-2, 19 71, to 10-4, 19 71, that (I) (we) last saw the deceased alive on 10-4 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Wm O Ellis Jr | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 10-4-71 | |
| 22d. PHYSICIAN'S NAME (Type): W. R. Ellis, Jr. | 22e. ADDRESS: Kay Drive, Salisbury, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 10/8/71 | 23c. NAME OF CEMETERY OR CREMATORY: PARKSLEY | 23d. LOCATION (City or Town): PARKSLEY | (County): Acc. (State): Va |
| 24. FUNERAL DIRECTOR: Anna A. Burbage | ADDRESS: Berlin Md. | 25a. REC'D BY REGISTRAR DATE: OCT 15 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15 (4)
25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

16055 16067

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARY | ELIZABETH | SHOCKLEY | October 25 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | February 27, 1875 | 96 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Hebron | 409 Walnut Street | House work | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Hebron | YES ☒ NO ☐ | 409 Walnut Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | William | Serman | Sara | Elizabeth | Sturgis |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Son) | Address |
|---|---|---|---|---|
| No | | | Mr. Lawrence E. Shockley, | same as 13e Hebron, Maryland |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Heart Failure | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Cerebral Accident | 6 mo |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arterio-Sclerosis | 10 yrs. |

4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1967, to 10/25, 1971, that (I) (we) last saw the deceased alive on Oct 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Seth W. Hurdle M.D. | | ☐ | ☐ | ☐ | October 27/1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Seth Hurdle | Hebron, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 28, 1971 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, P.A., Salisbury, Md. | NOV 1 1971 | Vernon B. Randall, |

OHMH-16 1/71 30M
(VR A15 4)

16056

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5, Film 6441 10/29/71 kam

## CERTIFICATE OF DEATH

16068

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: GEORAGE | Middle: WESLEY | Last: Sparrow SR | 2a. DATE OF DEATH Month: 10 Day: 15 Year: 71 | 2b. HOUR: 12 24 M |
| 3. SEX: Male | 4. RACE: WHITE | 5. DATE OF BIRTH: Oct. 25, 1891 | 6. AGE (In years last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Va | 7b. CITIZEN OF WHAT COUNTRY?: US | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Conductor | 12b. KIND OF BUSINESS OR INDUSTRY: RAIL ROAD | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Del | 13b. COUNTY: Sussex | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: State St. Ext. | |
| 14. FATHER'S NAME First: Alfred | Middle: | Last: Sparrow | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: | Last: Nock |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Fay Sparrow | Address: Delmar Del | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: 4123

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Arteriosclerosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While [ ] at work Not while [ ] at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. I **certify** that (I) (this hospitol) attended the deceased from 10/2, 19 71, to 10/15, 19 71, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: David J. Gilmore MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (Type): David J. Gilmore

22e. ADDRESS: Kay Drive, Salisbury, Md.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 10/17/71 | 23c. NAME OF CEMETERY OR CREMATORY: St Stephens Cem Rock | 23d. LOCATION (City or Town): Delmar | (County): Sussex | (State): Del |
| 24. FUNERAL DIRECTOR: William J. Nock | ADDRESS: Delmar Del | 25a. REC'D BY REGISTRAR DATE: OCT 26 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randle | | |

VR A15 (a) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16057

# CERTIFICATE OF DEATH

16069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Haywood; Middle: Frisco; Last: Thomas | 2a. DATE OF DEATH: Month October; Day 14; Year 71 | 2b. HOUR: 9:35 P.M. | |
| 3. SEX: Male | 4. RACE: Caucasian | 5. DATE OF BIRTH: 11/25/04 | 6. AGE (If under 1 year last birthday) YRS.: 66 — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN |
| 7a. BIRTHPLACE (State or foreign country): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wicomico Rehab- Booth St. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER- CHICKENS | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET AND NUMBER: 1735 Riverside Drive |
| 14. FATHER'S NAME First: Moss; Middle: T.; Last: Thomas | 15. MOTHER'S MAIDEN NAME First: Viola; Middle: ; Last: West | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO.: 219-07-6323A | 17. INFORMANT (Daughter) Address: same as 13e | Mrs. Gladys L. Carey, Salisbury, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Ca with mets — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO, OR AS A CONSEQUENCE OF (b): spread metastasis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this haspital) attended the deceased from 9/15, 19 71, to 10/14, 19 71, that (I) (we) last saw the deceased alive an _____ 19___, and that in (my) (aur) apinian death accarred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] DEGREE | ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ | 22c. DATE SIGNED: 10/15/71 | |
| 22d. PHYSICIAN'S NAME (Type): D.A.C. Mitchell | 22e. ADDRESS: Wicomico Rehab Center - Booth St. Salisbury | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Oct. 17, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland |
| 24. FUNERAL DIRECTOR ADDRESS: Holloway Funeral Home, Salisbury, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 19 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16058 — 16070

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| CHARLES | CLAYTON | TOOMEY | OCTOBER 28 1971 | 10:05 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| M | W | OCT. 11, 1919 | 52 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| DEL. | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hosp. | LUMBER MILL EMPLOYEE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | WICOMICO | PITTSVILLE | | — |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GORDY | | TOOMEY | ANNIE | | TOOMEY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WW II | 222-09-1255 | Elizabeth Toomey | Pittsville, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
485X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/14, 19 71, to 10/28, 19 71, that (I) (we) last saw the deceased alive on 10/28 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Ben Homer MD | | ☐ | ☐ | ☐ | 10/28/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11/1/71 | PAGESBORO MEM. GDN. | PAGESBORO, SUSSEX, DEL. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| A. Douglas Nelson | Frankford, Del. | NOV 3 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and cemetery filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

14 16059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16071

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Alma | MAMIE | Truitt | 10 | 6 | 71 | 5:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Female | Cauc. | 9/10/95 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | WIDOWED ☐ DIVORCED ☒ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Wicomico Rehab. Center | Seamtress-Retired | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES ☒ NO ☐ | 606 Light Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| HIRAM | JAMES | TRUITT | MARTHA | EMMA | JONES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Address) |
|---|---|---|
| NO | 214-10-6359 | Mr. Charles J. Truitt (Brother) Spring Hill Rd - Salisbury, Md. 21801 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA, MASSIVE
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIVERTICULOSIS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | N/A |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceosed alive an _____ 19____, and that in (my) (our) opinion death occurred on the dote ond hour ond from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| E. L. D. Dia | MD | ☒ | ☐ | ☐ | 10-7-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ELIAS LUIS D. DIA, MD | 516 E. 6th St. Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 8/1971 | Pittsville Cemetery (Old) | Pittsville, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HOLLOWAY FUN'L HOME P.A. | SALISBURY, MD. | OCT 12 1971 | Thomas P. Rundle |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
45M - 1/69

Items 18--22a Film 443 12/7/71 mn

16060

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16072

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: DEBBIE | Middle: ANNE | Last: TWILLEY | 2a. DATE KNOWN [X] OF ESTIMATED [ ] Month Doy Yeor: 10-31-71 | 2b. HOUR A.M.: 12:35 |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: 6-10-55 | 6. AGE (In years last birthday): 16 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.) | 2c. DATE PRONOUNCED DEAD Month 10 Doy 31 Yeor 71 | 2d. HOUR M |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Box 24 | |
| 14. FATHER'S NAME First: Richard V. | Middle: | Lost: Powell | 15. MOTHER'S MAIDEN NAME First: Laura | Middle: Evans | Lost: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Monty Twilley | ADDRESS: Delmar, Md. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Salicylate Poisoning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. 11 P.M. 10-23 19 71 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): Overdose of Aspirin |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Own Home | 21f. LOCATION Street or R.F.D. No. / City or Town: Delmar / County: Wic. / State: Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
22b. DATE SIGNED: Nov. 1, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/3/71 | 23c. NAME OF CEMETERY OR CREMATORY: St. Stephens | 23d. LOCATION (City or Town) (County) (State): Delmar Del. | |
| 24. FUNERAL DIRECTOR: Wallace Funeral Home | ADDRESS: Salisbury, Md. | 25a. REC'D BY REGISTRAR DATE: NOV 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16061

Item#5,13,17,FilmG442 11/8/71 kam **CERTIFICATE OF DEATH** 16073

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| LAURA | JEAN | TWILLEY | OCTOBER | 25 | 1971 | 12 Noon M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | White | 10/24/71 | YRS. | | | 3 | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md | U.S | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hosp. | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Delmar | YES ☐ NO ☐ | Box 24 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Monty | Twilley | | Debbie | Powell | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | Monty Twilley | Powellville, Delmar, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Perinatal Hypoxia

DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity

DUE TO, OR AS A CONSEQUENCE OF (c) Salicylate Intoxication - Maternal

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7619

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| William C. Morgan | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| William C. Morgan | Salisbury, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/28/71 | St Stephens Cem. | Delmar, Del. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE |
|---|---|---|
| Thompson, Bivalve, Md | NOV 2 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

16062

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16074

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: ROLAND | Middle: J. | Last: VICKERS | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] | Month Day Year: 10-9-71 19 | 2b. HOUR: 4:45 M |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: 11-4-11 | 6. AGE (In years last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month 10 Day 9 Year 19 71 |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | 2d. HOUR: " M |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DGA Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MAINTENANCE | 12b. KIND OF BUSINESS OR INDUSTRY: POULTRY PLANT | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Whaleysville | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Box 218 | | |
| 14. FATHER'S NAME First: EDWARD | Middle: | Last: VICKERS | 15. MOTHER'S MAIDEN NAME First: ANNIE MAE | Middle: | Last: LEWIS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. [redacted] | 16c. INFORMANT ADDRESS: EDITH VICKERS WHALEYVILLE MD. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I taak charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer, M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D. — 409 Camden Ave., Salisbury, Md. (ADDRESS(Street, city, town, or county))

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. **DATE SIGNED**: Oct. 12, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| BURIAL | 10-12-71 | DALE | WHALEYVILLE, WORCESTER, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Watson & Whaley, Selbyville, Md. | Peter Whaley | OCT 18 1971 | Vernon B. Randall |

VR A15ME (5) 8M-1/70

15 16063

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16075

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Dwight | W. | Wagner | 10 | 2 | 1971 | 3:50 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| Male | Caucasian | 7/14/1913 | 58 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Sales Rep-Vend-Corp. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☒ NO ☐ | 725 Ferndale Rd. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John L. | | Wagner | Jamie | | Watson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| Yes WW II | | Eloise J. Wagner, Mr. | 5711 Sherwood Dr. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 1561 IMMEDIATE CAUSE (a) | Adenocarcinoma of Common Bile Duct | 7 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Status Post Operative Cholecysto- | 7 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Tygnectomy | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from Sept. 27, 19 71, to Oct. 2, 19 71, that (I) (we) last saw the deceased alive an Oct. 2, 19 71, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John J. Calarco MD. | | | ☐ | ☒ | 10-2-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| JOHN J. CALARCO, M.D. | Deer's Head State Hospital, Salisbury Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Cremation | 10/2/71 | Cedar Hill | Washington, D.C. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| C.S. Mossuti, Blvd Ave, Md. | | OCT 7 1971 | Vernon R. Randolph |

VR A15 (3) 45M · 1/69

1

16064

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16076

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: ~~XXXXX~~ Carrie Middle: R. Last: WAINWRIGHT | 2a. DATE OF DEATH Month: October Day: 8 Year: 1971 | 2b. HOUR: 1 P. 13 M | |
| 3. SEX: Female | 4. RACE: Colored | 5. DATE OF BIRTH: May 30, 1890 | 6. AGE (In years lost birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Somerset Princess Anne | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First: Levin Middle: Last: Roberson | | 15. MOTHER'S MAIDEN NAME First: Betsy Middle: Last: Robersen | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: Albert Wainwright, Princess Anne, Md | |

80 19 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) C A of ovary c Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: [illegible]

1830

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 9-28, 1971, to 10-8, 1971, that (I) (we) last saw the deceased alive on 10-8 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William Q Ellis DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 10-8-71

22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS: (MT Zion)

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/12/71 | 23c. NAME OF CEMETERY OR CREMATORY: ~~XXXXXXXXXXXXXXXS~~ Chris M.E. | 23d. LOCATION (City or Town) (County) (State): Princess Anne, Md |
| 24. FUNERAL DIRECTOR: William H. James, Jr., | ADDRESS: 407 Somerset Ave., Princess Anne, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 15 1971 | 25b. REGISTRAR'S SIGNATURE: [illegible] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

13 16065

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16077

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: John | Middle: Thomas | Last: WALSTON | 2a. DATE OF DEATH: Month October | Day 12 | Year 1971 | 2b. HOUR: 11 AM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: April 26, 1880 | 6. AGE (In years last birthday): 91 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury - Peninsula General Hospital | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET AND NUMBER: Walston Switch Rd. | | | |
| 14. FATHER'S NAME First: Thomas T. | Middle | Last: Walston | 15. MOTHER'S MAIDEN NAME First: Unknown | Middle | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 216079681 | 17. INFORMANT: Wm. T. Walston | Address: Salisbury Md. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis, secondary to — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hr
DUE TO, OR AS A CONSEQUENCE OF (b): Perforated bowel, secondary to
DUE TO, OR AS A CONSEQUENCE OF (c): Intestinal Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5609

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ASCVD.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/11/71, to 10/12/71, that (I) (we) last saw the deceased alive on 10/12/71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10-14-71 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Parkwood | 23d. LOCATION (City or Town): Baltimore | (County): Md. (State) |
| 24. FUNERAL DIRECTOR: Thomas F. Hynes | ADDRESS: Snow Hill, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 18 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15 (4)
25m-11/70

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

16066

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DH-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: MATTIE | Middle: C. | Last: WARD | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: 10-7-71 19 | 2b. HOUR: 4:15 P M | | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: 5-12-95 | 6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month 10 Day 7 Year 71 19 | 2d. HOUR " M | | |
| 7a. BIRTHPLACE (State or foreign country): Md | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY: Clothing | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Pittsville | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Route 1 | | | |
| 14. FATHER'S NAME First: THOMAS | Middle: | Last: FARLOW | 15. MOTHER'S MAIDEN NAME First: KATE | Middle: | Last: TRUITT | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: William T. Ward | ADDRESS: Delmar Del | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] | |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: Oct. 8, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 10/10/71 | 23c. NAME OF CEMETERY OR CREMATORY: LIKE CEM | 23d. LOCATION (City or Town) (County) (State): DELMAR SUSSEX Del | |
| 24. FUNERAL DIRECTOR: Marvel Funeral Home, Delmar, Del. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: OCT 13 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon A. Randall | |

VR A15ME (5) 8M-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16067 (MINNIE) 16079

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MINNIE | VIVIAN | WARD | Oct. 5 1971 | 2:20 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN |
|---|---|---|---|---|---|
| Female | White | Feb. 10, 1899 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Crisfield | USA | WIDOWED [X] | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done durine most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Housewife | None |

| 13a. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Crisfield | YES [X] NO [ ] | 338 Pine St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Ira | - | Tull | Minnie | - | McDorman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | None | | Mrs. Vincent Neal, Salisbury, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
582X
IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal disease — yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). Congestive Heart Failure - Arteriosclerotic heart dis.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 9/16, 1971, to 10/5, 1971, thot (I) (we) last saw the deceased alive on 10/4/1971, and that in (my) (aur) opinion death occurred on the date and hour ond from the causes stated above. (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 10/7/71

22d. PHYSICIAN'S NAME (Type) Earl Beardsley, M. D. — 22e. ADDRESS Civic Ave., Salisbury, Md. 21801

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| Burial | Oct. 8, 1971 | Sunnyridge Cemetery | Crisfield, Somerset, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Bradshaw & Sons, Crisfield, Md. 21817 | OCT 13 1971 | Vernon R. Rardin |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (M)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

16068

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16080

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | 2b. HOUR |
|---|---|---|---|---|
| VIVIAN | L. | WARD | Month 10 Day 25 Year 1971 | 12:05 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| F | W | 11-15-44 | 26 YRS. | | | Month 10 Day 25 Year 1971 | 1 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| Delaware | USA | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | DOA Peninsula General | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Somerset | Marion | YES ☐ NO ☒ | Rt. #413 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Carl | P. | Ward | Anna | - | Knotts |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 219-42-8582 | Carl P. Ward, Same as 13. abode |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9520

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | 12:05 PM 10-25-71 | Self-inflicted - hose to car exhaust in garage. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | garage | Marion, Somerset, Md. |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒ Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED Oct. 26, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct 28, 1971 | St. Paul's Cemetery | Marion, Somerset Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Bradshaw & Sons, 306 W. Main St. Crisfield, Md. | NOV 1 1971 | Vernon G. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VR A13 Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16069 16081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Atha | Marguerite | Webster | Oct. 11 1971 | 10:40 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | July 22-1906 | 65 YRS. | - | -- | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Retired | Household |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Somerset | Deal Island | YES [X] NO [ ] | Main Rd |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Willie | C | Abbott | Nora | | Robinson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|
| No | Unknown | Baker Webster | Deal Island, Md 21821 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracranial hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

(b) Hypertensive arteriosclerotic cardiovascular disease. — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Recurrent cerebral vascular accidents, diabetes mellitus.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|

22a. I certify that (X) (this hospital) attended the deceased from 6/6, 19 67, to 10/11, 19 71, that (X) (we) last saw the deceased alive on 10/11 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| C. H. Winnacott, M. D. | | [ ] | [ ] | [X] | 10/11/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| C. H. Winnacott, M. D. | Deer's Head State Hospital, Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/13/71 | St Johns Cemetery | Deal Island Md SOM |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Leroy Webster | Princess Anne Md 21853 | OCT 15 1971 | Vernon R. Randall |

VR A15(4)
25m-1/70

1

16070

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

16082

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M
I

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| Kenneth | Paul | Wettig | October 25 1971 |

2b. HOUR 7:30 P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | 6-23-1904 | 67 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Wash. D.C. | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hosp. | Retired | U.S. Govt. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Worchester | Ocean City | YES ☒ NO ☐ | 909 Edgewater Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | C. | Wettig | Julia | M. | Supple |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | WWII | - | Pauline M. Grady | Berlin, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 no.
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD —
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 10-15-71 | Arteriosclerosis | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10-1, 19 71, to 10-25, 19 71, that (I) (we) last saw the deceased alive on 10-25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| E. Kent Carney | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 10-26-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| E. Kent Carney | Medical Center, Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | 10-29-71 | Culpepper Nat'l. Cem. | Culpepper VA. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Timothy Harlow Funeral Home 4248 Wise Ave. Wash., D.C. | NOV 8 1971 | Thomas A. Randall |

VR A15 (4)
25m-1/70

1 16071

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

16083

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Otto | M. | White | Oct | 2 | 1971 | 11:50 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Negro | 5/9/1909 | 62 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head State Hospital | Farmer / Waterman | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Jesterville | | Jesterville |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John O. | | White | Martha | Brooks | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | WW I | 214-28-7925 | Louise White | Jesterville, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple Myeloma & Infections | 1 yr. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Bilateral Nephrolithiasis | 1 yr. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Chronic Urinary Tract Infection | 1 yr. |

203X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Aug. 24, 19 71, to Oct. 2, 19 71, that (I) (we) last saw the deceased alive on Oct. 2, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John J. Calarco MD | | | ☐ | ☒ | October 2, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| JOHN J. CALARCO, M.D. | Deer's Head State Hospital-Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 10/9/71 | Jesterville Cem. | Jesterville | Md. | |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| C. M. Tassin & Son | Pocomoke City, Md. | OCT 8 1971 | Vernon R. Randall |

VR A15 (C)
45M - 1X 68

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

16072

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16084

| | |
|---|---|
| 1. DECEASED-NAME (Type or Print) First: VAUGHN Middle: Edward Last: WILMER | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year 10-31-71 19 |
| 2b. HOUR P 1:30 M | |
| 3. SEX: M | 4. RACE: W |
| 5. DATE OF BIRTH: 6-30-16 | 6. AGE (In years last birthday) 55 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 2c. DATE PRONOUNCED DEAD Month 10 Day 31 Year 71 19 | 2d. HOUR " M |
| 7a. BIRTHPLACE (State or foreign country): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DUA Peninsula General |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Insurance Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Ret. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wicomico |
| 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: 104 W. Chestnut St. | |
| 14. FATHER'S NAME First Middle Last: Edward Wilmer | 15. MOTHER'S MAIDEN NAME First Middle Last: Anna Byrd Wilmer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) — | 16b. SOCIAL SECURITY NO. 223-14-9493 |
| 17. INFORMANT ADDRESS: Mrs. Frances Hudson Wilmer (Same as 13e) | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardio-vascular Disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type) Earl L. Royer, M.D.
409 Camden Ave., Salisbury, Md. ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Nov. 1, 1971

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 11/3/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Pk. | 23d. LOCATION (City or Town) (County) (State): Salisbury Md. |
| 24. FUNERAL DIRECTOR ADDRESS: Hill-Baker-Bounds, Salisbury, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

FOR STATE HEALTH DEPT.

16073

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16085

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form plus Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: CATHERINE | Middle: | Last: WILSON | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 10-13-71 | | | 2b. HOUR: 7:05 A M |
| 3. SEX: F | 4. RACE: AA | 5. DATE OF BIRTH: 2-1-33 | 6. AGE (In years last birthday): 38 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month 10 Day 13 Year 19 71 | 2d. HOUR M |
| 7a. BIRTHPLACE (State or foreign country): S C. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deers Head Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Queen Anne's | 13c. CITY OR TOWN: Grasonville | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Box 46 | | | |
| 14. FATHER'S NAME First: Tolley | Middle: Homm | Last: | 15. MOTHER'S MAIDEN NAME First: Cora | Middle: Lucas | Last: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): — | 16b. SOCIAL SECURITY NO.: 219-42-7313 | 17. INFORMANT: Calvin | ADDRESS: Wilson | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Concussion with Contusions — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

8191 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR 6:55 P.M. 8-7-71 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | Passenger in vehicle involved in acc. |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | bridge | Narrows Bridge | Kent | Q. Anne's | Md. |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Oct. 14, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | 10/17/71 | Robenson | Grasonville Qx Md |

24. FUNERAL DIRECTOR: George Dashiell, Easton, Md. ADDRESS: 9 West St

25a. REC'D BY REGISTRAR DATE: OCT 20 1971

25b. REGISTRAR'S SIGNATURE: Vernon B. Randall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16074

# CERTIFICATE OF DEATH

16086

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in all the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removol, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Eleanor | Middle: M. | Last: WILSON | 2a. DATE OF DEATH Month: October | Day: 26 | Year: 1971 | 2b. HOUR: 6:48 PM |
| 3. SEX: FEMALE | 4. RACE: Negro | 5. DATE OF BIRTH: 2-19-13 | 6. AGE (In years last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): FRUITLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: FRUITLAND | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: POPLAR ST. | | | |
| 14. FATHER'S NAME First: LEWIS | Middle: DASHIELL | Last | 15. MOTHER'S MAIDEN NAME First: GEORGIA | Middle: JONES | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 220-10-8249 | 17. INFORMANT: VIVIAN McCULLOUGH | Address: SALISBURY, MD - 725 BOOTH ST. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): diabetic acidosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): marked diabetes of (2) yrs
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Nat while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/22, 19 71, to 10/26, 19 71, that (I) (we) last saw the deceosed alive on 10/26 19 71, and thot in (my) (aur) opinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: W. Benjamin Horner MD | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 10/28/71 | |
| 22d. PHYSICIAN'S NAME (Type): W. Benjamin Horner, M.D. | 22e. ADDRESS: Kay Drive, Salisbury, Md. 21801. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10-31-71 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. CALVARY | 23d. LOCATION (City or Town): FRUITLAND | (County): Wico. (State): Md |
| 24. FUNERAL DIRECTOR: Loretta L. Jolley | ADDRESS: Jolley Funeral Chapel - Jersey Rd. Rt 13 Salis. Md | 25a. REC'D BY REGISTRAR DATE: NOV 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15(M) 25m-1/70